

CMS-1500 (version 02-12)

Claim Form Instructions

May 28, 2014



Change history

Date (mm/dd/yyyy)	Description of changes	Impact
02/10/2014	Initial version	
05/28/2014	Changes include additional examples for Field 24E – Diagnosis pointer	Pages 2, 4, 7, 9



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These instructions address Nevada Medicaid paper claim requirements.

If you submit electronic claims through a clearinghouse, please contact the clearinghouse directly if you have a question specific to submitting a claim or receiving an electronic remittance advice. To register to submit electronic claims to Medicaid, see the [Electronic Claims/EDI](#) webpage online at <http://www.medicaid.nv.gov>. The EDI webpage contains EDI enrollment forms, announcements and companion guides.

Questions?

If you have any questions, please call the Customer Service Center at (877) 638-3472.

Claims mailing address



HP Enterprise Services
PO Box 30042
Reno, NV 89520-3042

Adjustments, voids and any other written correspondence may also be sent to this address.

Provider training

HP Enterprise Services and the Division of Health Care Financing and Policy (DHCFP) offer free training classes throughout the year.

The [Provider Training Catalog](#) describes the training program and lists current training schedules. Billing staff, billing agencies, direct practitioners/health care providers, office managers, admitting and front-desk staff, etc. are invited to attend.

If you have questions or comments regarding training, contact the HP Enterprise Services Provider Training Unit at:

Phone: (877) 638-3472 (select option 2, then option 0, then option 4)

Email: NevadaProviderTraining@hp.com

Web announcements

Web announcements appear on the [homepage](#) at <http://www.medicaid.nv.gov> and on the Announcements/Newsletters webpage.

Be sure to check this website at least weekly for these important updates.



Adjustment/Void reason codes for Field 22

To adjust or void a *previously paid* claim, use an adjustment or void reason code to complete the CODE area of Field 22 (RESUBMISSION CODE). Resubmitting a *denied* claim is not considered an adjustment or void.

Adjustment reason codes

Use one of the following codes in Field 22 when adjusting a previously paid claim.

Code	Definition
1021	Late charges received by facility business office
1023	Primary carrier has made additional payment
1028	Correcting procedure/service code
1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units, visits or studies
1034	Correcting quantity dispensed
1035	Correcting drug code
1037	Services not covered by Medicare
1041	Incorrect amount paid for original claim
1042	Original claim has multiple incorrect items
1053	Adjustment (miscellaneous)

Void Reason Codes

Use one of the following codes in Field 22 when voiding a previously paid claim.

Code	Description
1044	Wrong provider identifier used
1045	Wrong Recipient ID used
1047	Duplicate payment
1048	Primary carrier has paid full charges
1052	Miscellaneous
1060	Other insurance is available



CMS-1500 (02-12) field requirements

Required

Fields marked *Required* in the claim form instructions are required on all paper claim submissions. The claim may be denied or returned if a *required* field is incomplete. For example, the recipient's 11-digit Recipient ID (Enrollee ID) as shown on their Medicaid card must be entered in Field 1a.

Situational

Fields marked *Situational* are required when they apply to the claim. For example, Field 9a (marked *Situational*) must be populated with the policy or group number only when TPL applies.

Recommended

Fields marked *Recommended* are not required, but will be returned with the provider's remittance advice if supplied on the claim. For example, if the provider's in-house, patient account number is provided in Field 26, it will be returned on the remittance advice, thereby allowing billing staff to cross reference the claim with the provider's records if needed.

Not Required

Fields marked *Not Required* are not used in processing the claim, although the provider is free to populate the field if desired. For example, providers may use Field 3 to enter the recipient's birth date and sex, but the data will not be used to adjudicate the claim.

Third Party Liability claims

Third Party Liability (TPL) claims, including Medicare crossover claims, may contain only one completed claim line per claim form.



Shaded CMS-1500 (02-12) field requirements

The CMS-1500 (02-12) claim form is shown below with Nevada Medicaid *Required* fields shaded red, *Situational* fields shaded blue, and *Recommended* fields shaded green. (On a non-color printout, *Required* fields will appear darkest.)

1. MEDICARE, MEDICAID, TRICARE, CHAMPVA, COBRA/HEALTH PLAN, GROUP, OTHER												1a																	
2												4																	
5												6		7															
9												10		11															
9a												11a		11b															
9d												11c		11d															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE												13. PHYSICIAN'S OR AUTHORIZED PERSON'S SIGNATURE																	
14												15		16															
17												17b		18															
19												20		21															
21												22		23															
24. A. DATE OF SERVICE												B. PLACE OF SERVICE		C. PROCEDURE, SERVICE, OR SUPPLY		D. EXAMINER		E. EXCHANGES		F. ICD-9-CM		G. ICD-9-CM		H. ICD-9-CM		I. ICD-9-CM		J. ICD-9-CM	
A												B		C		D		E		F		G		H		I		J	
2																													
3																													
4																													
5																													
6																													
25												26		27. ACCEPT ASSIGNMENT		28		29		30									
31												32		33		33a		33b											



Instructions for completing the CMS-1500 (02-12) claim form

Field	Requirement	Field Name and Instructions for CMS-1500 (02-12) Claim Form
1	Not Required	Indicate the type of health insurance coverage applicable to this claim: Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA Black Lung, Other
1a	Required	Insured's ID number: Enter the recipient's 11-digit Recipient ID (Enrollee ID) as shown on their Medicaid card.
2	Required	Patient's name: Enter recipient's full last name, first name and middle initial as indicated on the Medicaid ID card.
3	Not Required	Patient's birth date, sex: Enter the recipient's birth date in MM DD CCYY format. Enter an X in the correct box to indicate the recipient's gender.
4	Recommended	Insured's name
5	Recommended	Patient's Address, City, State, Zip Code, Telephone
6	Recommended	Patient relationship to insured
7	Recommended	Insured's Address, City, State, Zip Code, Telephone
8	Not Required	This field is reserved for NUCC use.
9	Recommended	Other insured's name
9a	Situational	Other insured's policy or group number: <i>Recipient has TPL with Medicare coverage:</i> Enter the recipient's Medicare number. <i>Recipient has TPL with commercial coverage:</i> Enter the recipient's identifier with their primary carrier.
9b	Not Required	This field is reserved for NUCC use.
9c	Not Required	This field is reserved for NUCC use.
9d	Situational	Insurance plan name or program name: <i>Recipient has Medicare coverage:</i> Enter the word <i>Medicare</i> followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus). <i>Recipient has TPL with commercial coverage:</i> Enter the name of the primary carrier.
10a-c	Situational	Is patient's condition related to: If the recipient's condition is a result of a work-related circumstance/occurrence, an automobile accident or other type of accident, check YES on the appropriate line.



Field	Requirement	Field Name and Instructions for CMS-1500 (02-12) Form
10d	Not required	Reserved for local use
11	Situational	Insured's policy group or FECA number: <i>Recipient has two forms of TPL — commercial:</i> Enter the policy number of the secondary carrier. <i>Recipient's Secondary Carrier is Medicare:</i> Enter the policy number of the primary carrier. (Medicare information is entered in Fields 9–9d).
11a	Situational	Insured's date of birth, sex
11b	Situational	Other Claim ID (Designated by NUCC)
11c	Situational	Insurance plan name or program name: Recipient has two forms of TPL — commercial: Enter the name of the recipient's secondary carrier. Recipient's Secondary Carrier is Medicare: Enter the name of the primary carrier (Medicare information is entered in Fields 9–9d).
11d	Situational	Is there another health benefit plan? If yes, complete items 9, 9a and 9d.
12	Not required	Patient's or authorized person's signature
13	Not required	Insured's or authorized person's signature
14	Situational	Date of current illness, injury, or pregnancy Enter the date (MM DD YY format) if any of the following are applicable: <ul style="list-style-type: none"> • For services related to an illness, enter the date that the first symptoms occurred. • For injury-related services, enter the date of the accident. • For chiropractic services, enter the date of the first treatment. • For pregnancy-related services, enter the date of the first day of the woman's last menstrual period (LMP).
15	Situational	If patient has had same or similar illness
16	Situational	Dates patient unable to work in current occupation
17	Required	Name of referring provider or other source
17a	Not required	Not labeled
17b	Required	NPI
18	Situational	Hospitalization dates related to current services



Field	Requirement	Field Name and Instructions for CMS-1500 (02-12) Form
19	Situational	Additional Claim Information (Designated by NUCC): <i>Laboratory services:</i> Enter the provider's CLIA number. <i>Anesthesia services:</i> Enter the total minutes of reportable anesthesia time. <i>All Other Providers:</i> Leave this field blank.
20	Not required	Outside lab? \$charges
21	Required	Diagnosis or nature of illness or injury: Enter up to twelve (12) ICD-9 codes in the spaces indicated A through L. Please enter the codes across each line, not down. <i>Please refer to the Billing Guide for your provider type for further instructions.</i>
22	Situational	Resubmission Code: Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. <ul style="list-style-type: none"> • In the <i>Code</i> area, enter an adjustment or void reason code (see section, <i>Adjustment/Void reason codes for Field 22</i>). • In the <i>Original Reference Number</i> area, enter the last <i>paid</i> Internal Control Number (ICN) of the claim. Adjustments and voids apply to previously <i>paid</i> claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment.
23	Situational	Prior authorization number: If you obtained authorization for an item on this claim, enter your 11-digit Authorization Number in this field. Enter only one Authorization Number per claim form. Complete additional forms if needed.
24A	Required	Date(s) of service: <i>Dates:</i> In the bottom, white half of the claim line, enter the begin (<i>From</i>) and end (<i>To</i>) dates of service. If a service was provided on one day only, enter the same date twice. In the top, shaded half of the claim line, enter qualifier N4 followed by the drug's 11-digit NDC . The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. <i>Continued on the next page.</i>



Field	Requirement	Field Name and Instructions for CMS-1500 (02-12) Form
24A	Required	<p><i>Continued from the previous page.</i></p> <p>To facilitate this, you must add leading zeros to one or more sections of the NDC if the container label does not display:</p> <ul style="list-style-type: none"> • 5 digits in the first section of the NDC • 4 digits in the second section of the NDC • 2 digits in the third section of the NDC <p>For example, using the 5-4-2 model described above:</p> <ul style="list-style-type: none"> • 34-73-1 on the container label is expressed as 00034007301 on the claim • 654-3773-22 on the container label is expressed as 00654377322 on the claim • 1645-222-65 on the container label is expressed as 16457022265 on the claim • 12345-6-7 on the container label is expressed as 12345000607 on the claim • 86541-4885-77 on the container label is expressed as 86541488577 on the claim <p>For multi-ingredient compounds, list each component separately, on its own claim line with the 11-digit NDC in this field.</p> <p>For more information and examples on billing physician administered drugs, see the NDC Billing Reference on the HP Enterprise Services website.</p>
24B	Required	<p>Place of service: Use the most appropriate Place of Service code in the bottom, white half of the claim line.</p>
24C	Not required	EMG
24D	Required	<p>Procedures, services or supplies CPT/HCPCS modifier:</p> <p><i>CPT/HCPCS Code:</i> Enter <i>one</i> CPT or <i>one</i> HCPCS code and up to four modifiers on the bottom, white half of the claim line.</p> <p>In the top, shaded half of the claim line, enter the NDC quantity, i.e., the number of NDC units administered. Fractions of a unit should be expressed in decimal form using up to three decimal places.</p> <p>Do not include the NDC standard unit of measure on your claim, i.e., <i>milliliters, grams or each</i>.</p>



Field	Requirement	Field Name and Instructions for CMS-1500 (02-12) Form
24E	Conditional (Required if any codes are entered in Field 21)	<p>Diagnosis pointer: In the bottom, white half of the claim line, enter the line letter or letter range (i.e., first and last letter) of the ICD-9 code(s) in Field 21 that relate(s) to the CPT/HCPCS code on this claim line. If there are five (5) or more diagnosis codes in Field 21, then a dash must be used between the letters.</p> <p>Examples on how to enter data in this field when codes are entered in Field 21:</p> <ul style="list-style-type: none"> • If you enter a code only in space A, then enter A in Field 24E. • If you enter codes in spaces A and B, then enter AB or A-B in Field 24E. • If you enter codes in spaces A through C, then enter ABC or A-C in Field 24E. • If you enter codes in spaces A through D, then enter ABCD or A-D in Field 24E. • If you enter codes in spaces A through E, then enter A-E in Field 24E. • If you enter codes in spaces A through D and I through L, then enter A-L in Field 24E. • If you enter codes in spaces A through E and in space G and in spaces I through K, then enter A-K in Field 24E. <p>Please refer to the Billing Guide for your provider type for further instructions.</p>
24F	Required	<p>\$ Charges: In the bottom, white half of the claim line, enter your usual and customary charge for the CPT/HCPCS/NDC on this claim line unless otherwise directed by Medicaid policy (e.g., physician administered drugs are billed at the Average Wholesale Price (AWP) and per MSM Chapter 300, radiopharmaceuticals are billed at 100% of wholesale invoice price).</p>
24G	Required	<p>Days or units: In the bottom, white half of the claim line, enter the number of days or the number of units being billed.</p> <p>For NDC quantity, see Field 24D.</p>
24H	Situational	<p>EPSDT/family plan: For providers that bill Family Planning services: In the bottom, white half of the claim line, enter Y if services were Family Planning and N if they were not.</p> <p>EPSDT services are identified by EP or TS modifiers used in Field 24D.</p>
24I	Recommended	<p>ID qualifier:</p> <p>Using NPI in Field 24J: Enter ZZ in the top, shaded half of the claim line.</p> <p>Using API in Field 24J: Enter N5 in the top, shaded half of the claim line.</p>
24J	Recommended	<p>Rendering provider ID#:</p> <p><i>NPI Users:</i> Enter the provider's taxonomy code in the top, shaded half of the claim line.</p>
	Required	<p><i>API Users:</i> Enter the provider's API in the top, shaded half of the claim line.</p> <p><i>NPI Users:</i> Enter the provider's NPI in the bottom, white half of the claim line.</p>



Field	Requirement	Field Name and Instructions for CMS-1500 (02-12) Form
25	Recommended	Federal tax ID number: Enter the billing provider's Social Security Number (SSN) or Employer Identification Number (EIN). Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	Recommended	Patient's account number: Enter up to 17 alpha-numeric characters for your internal patient account number. If entered, this information will be returned to you on your remittance advice.
27	Not required	Accept assignment?
28	Required	Total charge: Add all amounts in column 24F. Enter the total in this field.
29	Situational	Amount paid: If the recipient has TPL, enter the amount paid by all other carriers, including Medicare, for the HCPCS/CPT and/or NDC on this claim form. Do not enter the amount received for <i>all</i> services on your EOB, and do not include write-off or contractual adjustment amounts. For providers with capitated agreements, enter the contract amount minus co-pay. A zero paid amount is not acceptable for capitated agreements.
30	Required	Balance due (Reserved for NUCC Use) <i>Medicaid is primary coverage:</i> enter the amount shown in Field 28. <i>Recipient has TPL (including Medicare):</i> Enter the recipient's legal obligation to pay. Do not include write-off, contractual adjustment or behavioral health reduction amounts.
31	Required	Signature of physician or supplier: The billing provider or authorized representative must sign and date this field. Original, rubber stamp and electronic signatures are accepted.
32	Situational	Service facility location information: Enter the name and full address of the location where service was rendered. If the service was rendered in the recipient's home, leave this field blank. Ambulance providers: Do not enter <i>From</i> and <i>To</i> dates in this field.
32a	Not required	NPI#
32b	Not required	Other ID#
33	Required	Billing Provider Info & Ph#: Enter the full address of the billing provider.
33a (NPI providers only)	Required	NPI#: <i>For NPI providers only:</i> Enter the billing provider's NPI.
33b	Situational	Other ID#: <i>API Users:</i> Enter N5 followed by the billing provider's API. <i>NPI Users:</i> Enter ZZ followed by a taxonomy code when available. Do not use spaces, hyphens, dashes, commas, etc. in this field. For example, N51234567899 (for API user) and ZZ1234567899 (for NPI user).

